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CRC-STAT

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DIAGNOSTIC ASSESSMENT REFERRAL FORM
For Clinical Suspicion of Colorectal Cancer

Nurse Navigator Telephone: 416-864-6060 Ext. 2765 Fax: 416-864-5250
Please note – Referrals are triaged and booked by Physician Offices

PATIENT INFORMATION			
Last Name First Name		Date of Birth:	Gender: ☐ M ☐ F
Health Card#	Version Code:	Previous SMH Patient: ☐ YES ☐ NO MRN: if known	
Street Address:	City:	Province:	Postal Code:
Phone: Home	Cell:	Work:	
Alternate Contact Name:	Relationship:	Phone: Home	Other:

APPOINTMENT INFORMATION

- Patients who are FOBT+ will be scoped within 8 weeks of abnormal result
- Committed to rapid assessment based on relevant history
- Additional tests will be coordinated following the assessment appointment

ColonCancerCheck Referral Criteria

- ☐ Positive FOBT from routine screening (age 50-74 only) Please attach copy of FOBT result
- ☐ First-degree relative diagnosed with colorectal cancer
- ☐ Patient must be ≥ 40 yrs of age, OR
- ☐ 10 yrs < the earliest age of diagnosis of the first degree relative

Symptomatic Referral Criteria

- ☐ Palpable rectal mass
- ☐ Rectal bleeding
- ☐ Unexplained weight loss
- ☐ Risks factors for colorectal cancer
- ☐ History of colorectal polyps or IBD
- ☐ Unexplained iron deficient anemia
- ☐ Abnormal imaging suggesting a mass
- ☐ *attach imaging report
- ☐ Palpable abdominal mass
- ☐ Change in bowel habits

REFERRAL INFORMATION (TO BE COMPLETED AND SIGNED BY REFERRING PHYSICIAN)

Reason for referral:

List of current medical problems and medications:

Referring Physician	Billing#	Phone	Fax
Family Physician		Phone	Fax

Signature of Referring Physician *(Mandatory)*

Date:(mm/dd/yyyy) _____

SMH USE ONLY	**Date Received:**	**Procedure Date/Time:**
Colonoscopist:		**MRP:**